PROGRESS

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IN THIS ISSUE

AWARENESS · KNOWLEDGE · UNDERSTANDING
PREVENTION

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PROGRESS

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Editor: J. MOTYL

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Volume IV, Number 4 **CONTENTS** Edmonton, March, 1963

A DECADE OF SERVICE

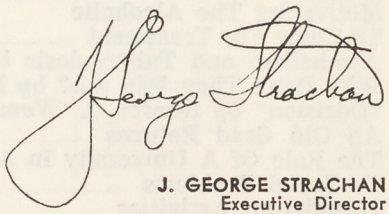
With this issue of PROGRESS, The Foundation is reaching the 10th Anniversary of its programming in the Province of Alberta. Although officially incorporated under the Societies Act in 1951, we formally began our operations in July 1953, with the opening of the Edmonton Centre.

Growth has been continuous and services are now being rendered in Edmonton, Calgary, Lethbridge, Medicine Hat, Red Deer, Westlock and Grande Prairie. In 1962, additional facilities were provided to implement and expedite all educational, research and administrative services throughout the province, through the acquisition of another building in Edmonton. This has enabled the clinic to function as a separate unit. We recently opened an addition to the Calgary Centre and clinic, to better service the southern part of the Province. Increasing demands on Foundation services are extensive and Foundation activities are now being felt and utilized in every stream of life and activity throughout the Province. While the treatment of the individual patient remains our foremost responsibility, orientation and training services have been expanded again and again into every facet of both the professional and lay health, welfare and rehabilitation organizations. Continuing studies of drinking habits in Alberta will help us assess and deal with the numerous problems related to the abuse of alcohol as reflected in alcoholism. This is paramount if we are to continue to strive successfully for solutions to and prevention of this widespread medical and social disorder.

Looking forward to the 10th Anniversary of The Foundation's services, we express to you, our members throughout the Province, our deep and sincere thanks for your continued support and cooperation. The Provincial Government has stood behind our work in so many ways that it is difficult to pay adequate tribute to their generous understanding and assistance. Our Boards and Executive Committees have contributed greatly towards guiding the work of The Foundation throughout all its years of development. Staff, past and present, are without parallel in the dedication of their services. The support of other agencies, and the cooperation of Alcoholics Anonymous, all further our progress in the treatment of alcoholic patients. The financial contributions of so many industries, associations, United Community Funds and individual members, have facilitated the development of especial activity.

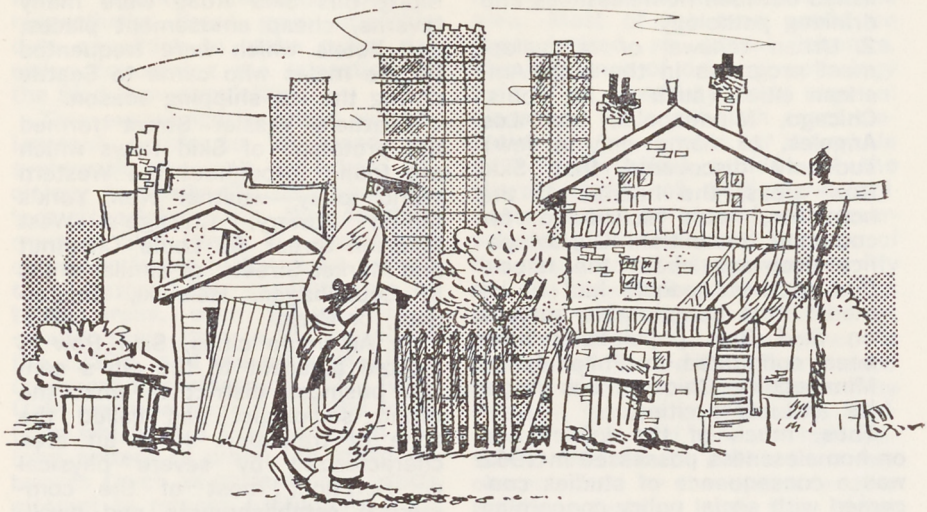
As, therefore, we see the integration of Foundation services into the life stream of our communities within the Province, we are grateful for that which we have done through their help and are mindful of all that can and must still be done through such continued support. All these contributions have created a climate of operation without which the functioning of The Alcoholism Foundation of Alberta would be difficult indeed.

It is refreshing and stimulating to believe, and see at work, these forces that have due regard for the humanities, which we do perhaps tend to neglect in the pressures of the materialistic and technical world we are today. As our approaches to the problems of the alcoholic change and improve, may we ever be conscious of our primary goals in the recovery and regeneration of the alcoholic and in the true dignity of man.



J. GEORGE STRACHAN
Executive Director

SOCIAL PATHOLOGY, URBAN RENEWAL AND THE HOMELESS MAN



Paper presented at the American Psychological Association meetings, St. Louis, 1962.

by David J. Pittman, Ph.D., Washington University

FIRST, let me indicate that I do not agree that research on the homeless man is the last social psychological frontier — there will always be many. But since it is popular today to talk about "Frontiers"—especially the "New Frontier," let us discuss an old Frontier as far as sociology is concerned.

Since the pioneer classic sociological study, **The Hobo: The Sociology of the Homeless Man,** by Nels Anderson in the early 1920's, students of social pathology and urban sociology have shown a concern with this research area. Anderson, whose research technique was basically participant observation oriented, brought keen insights to understanding the phenomenon of homeless men, but little in the way of statistical data.

Sociological interest in homelessness continued into the 1930's, mainly as a consequence of the severe economic dislocations of the Depression Decade. Anderson is again represented with his monograph, **Men On the Move.** It can be safely stated that in the 1930's, homelessness, far from being a deviant phenomenon, was the norm for a significant portion of the lower socioeconomic group.

Sociological interest in homelessness decreased with the full employment of World War II and its aftermath in the decade of the 1940's. However, during the 1950's two major interests, or more appropriately, social movements, stirred the dormant interest in homelessness. These were:

1. **The public health approach to**

alcoholism which began to view this disorder in disease instead of moral terms. A significant relationship had already been established between homelessness and drinking pathology.

2. Urban renewal or redevelopment programs in the large American cities (such as St. Louis, Chicago, Minneapolis, and Los Angeles, to name only a few) suddenly discovered that Skid Row areas, the habitat of the homeless, were scheduled for complete demolition. Crucial policy decisions about the relocation of these people had to be made; thus innumerable surveys on Skid Row populations have been conducted in Philadelphia, Minneapolis, Chicago, Los Angeles and other cities.

Thus, much of the information on homelessness possessed in 1962 was a consequence of studies concerned with social policy concerning Skid Row and rehabilitation of Skid Row problem drinkers.

Therefore, this paper will approach the subject of homelessness in terms of two basic assumptions. These are:

1. Skid Row, the center of homelessness and a specific locale in every major American city, serves concrete social psychological functions, both manifest and latent, in the metropolitan community.

2. Homelessness in the male is symptomatic of more fundamental disturbances in either the economic structure of the society, i.e., the Depression, or in the social psychological makeup of the individual, i.e., pathologies of alcoholism and psychiatric disease or both—the interaction of the socioeconomic position of the individual with his personal pathology.

Skid Row—A Social Portrait

The term, Skid Row, appears to have originated in Seattle at the turn of the 20th century. Yessler Street which sloped to Puget Sound was greased and logs were skidded down the street into the Sound. Along this Skid Road were many taverns, cheap amusement places, and hotels which were frequented by the males who came to Seattle during the log shipping season.

Seattle's Yessler Street formed the prototype of Skid Rows which are found throughout the Western World today—whether New York's famed Bowery, Chicago's West Madison Street, St. Louis' Chestnut and Market Streets, or similar areas in Copenhagen, Helsinki, Amsterdam, or Paris.

In American cities, Skid Row is located adjacent to the city's central business district in what the urban sociologist has called the zone of transition. It is an area characterized by severe physical deterioration; most of the commercial establishments and dwelling units are substandard. Institutional facilities are of the most marginal nature, composed of numerous cheap restaurants, hotels and "flophouses," religious missions and men's service centers, pawn shops and second-hand clothing stores, and drinking establishments.

Despite its unattractive appearance, the physical and social psychological needs of a small section of America's urban population are met in these areas. In the early days of urban redevelopment certain American cities planned to destroy these Skid Row areas through bulldozer demolitions. This naive assumption was constructed on the premise that Skid Rows were only a collection of obsolescent buildings. Much to the surprise of these planners, Skid Rows which were previously confined to one or at the most two areas of the cities metastasized to many locations in the city. In short, Skid Row relocated, multiplying itself in the process. Later plans for redevelop-

ment of Skid Row in such cities as Philadelphia and Chicago were preceded with social science surveys, by Temple University, and the National Opinion Research Center, respectively; these gave scientific data on which to make policy decision concerning the relocation of the Skid Row population.

This experience in urban redevelopment points to the need for systematic research in urban sociology to study the historical factors associated with the development of Skid Rows, the social and economic forces in American society that further the continuance of these areas, even though on a smaller scale than in the period of the 1920's, and the patterns of recruitment to residence on Skid Row. Until we know more about the functions which Skid Row serves in the total pattern of urban life, most attempts (such as current ones which attempt to remove individuals from this milieu through individual therapeutic techniques) to abolish Skid Row will be doomed to failure. We, thus, must learn what combination of societal and individual factors gives rise to Skid Rows and continue their existence.

Skid Row Residents

As a consequence of research studies and theorizing in the last decade by Dunham, Jackson and Connor, Bogue, the Temple University research group, and others on the problems of Skid Row and its inhabitants, a vast amount of information is currently available to interested parties.

We have only time to briefly summarize the major findings from these studies. The Skid Row population has been declining in number for the last few decades and has undergone significant changes. Although it is still almost exclusively male in composition, it has been a less mobile population. A significant proportion of the men are permanent residents who are characterized by poverty and homelessness. Residence is found in the numerous missions, cheap hotels, and flophouses which are indigenous to the area. Most of the men would be characterized as casual laborers. The incidence of drinking pathology as well as psychiatric and physical disease is high, although exact statistics are unavailable for the whole nation. Statistical profiles of the characteristics of Skid Row residents should be viewed with reservations, given the social isolation of the men from the larger community and the close-knit social organization of some subgroupings on Skid Row. An illustration of one subgroup is that of the "Bottle-Gang," organized around obtaining wine, observed by Pittman, Gordon and Rooney. Earlier, Jackson and Connor had observed that Seattle's Skid Row was characterized by the existence of a prestige system, and that there were group definitions for sharing alcohol, and that the men had developed systems for protecting each other from arrest for drunkenness.

Though Bogue and his associates in their study of Chicago's Skid Row found that the majority of men residing there could not be defined as alcoholics or excessive drinkers, the incidence of problem drinking cases is high in the Skid Row area. It is this area which contributes proportionately the largest share to the public drunkenness problem, both in arrests and incarcerations, in any urban center.

Alcoholism and the Homeless Man

Since the end of World War II there has been a vast proliferation of state and municipal programs dealing with alcoholism education, treatment, and research. The hard core of alcoholism cases are found in the 10 to 15 per cent of the alcoholic population which resides on Skid Row. These individuals

comprise the largest portion of the over one million arrests made annually in the United States on the charge of public intoxication or drunkenness. A large number of these police actions involve the repeated arrest of the same men. These chronic drunkenness offenders are the men who are arrested, convicted, sentenced, jailed and released, only to be rearrested—often within hours or days. They are the men from Skid Row for whom the door of the jail is truly a revolving door.

In a research study completed several years ago, by Pittman and Gordon, on 187 cases of a random sample of men sentenced at least twice to a penal institution on a charge of public intoxication and at that time incarcerated in the county jail, much detailed information was gathered on the chronic drunkenness offender. This man's usual habitat when not incarcerated is Skid Row — thus, the relevance to this discussion.

The materials for this section are drawn from the book, **Revolving Door.**

The extensive case histories of these chronic drunkenness offenders may be analyzed in terms of three major sets of factors which are crucial for the development of career patterns in public intoxication. These are: (1) sociocultural determinants; (2) socialization determinants; and (3) alcohol as the adaptive or adjustive mechanism in the life career.

1. Sociocultural Determinants

This offense category consists of individuals with definable sociocultural traits such as age, nationality, marital status, educational attainment, and occupational skills.

Age is a major factor that differentiates these men from all other offender groups. Their age curve is skewed toward middle-age brackets. Their mean age of 47.7 years, their median age of 48.5 years, is higher than that of the general male population, of arrested inebriates, and of patients seen in the alcoholism clinics.

The most frequently represented nationality groupings are English and Irish. Irish ethnics compose 35 per cent of the sample, but there is an increasing number of Irish with advancing age, especially after 45. Italians, although represented in significant numbers in the county's general population, compose only 2 per cent of the sample.

The current marital status of these men is an important attribute. Forty-one per cent never married, 32 per cent are separated, 19 per cent are divorced, 6 per cent widowed and 2 per cent were living with their spouses before the current incarceration. Thus, of these offenders 96 per cent of those who had ever married reported broken marriages, whereas the expectancy is only 11 per cent, using the general male population of the county corrected for age disparities as the control.

On the whole these offenders are an educationally disadvantaged group. Seventy per cent of the sample did not go beyond the eighth grade of school compared to 40 per cent of the county's general population. This educational impoverishment is reflected in their low order of primary occupational skills. Sixty-eight per cent are unskilled workers, mainly laborers, 22 per cent skilled workers, and 3 per cent professional and allied workers, compared to 13, 46, and 22 per cent in the respective categories in the general population.

In summary, lower class individuals of Irish ethnic status and Negroes in the age bracket 40-49 with previous extensive arrest histories are most vulnerable to repeated arrests for drunkenness.

2. Socialization Determinants

Within this framework of sociocultural determinants are a series of socialization experiences which are conducive to the development of a career pattern in inebriation. The structural continuity of the family units was broken by death, divorce, or separation before the inebriate's 15th birthday in 39 per cent of the cases. This is an extremely high percentage of families whose structure collapsed.

On a more qualitative level, mother-son and father-son relationships evidenced a trend in the direction of serious deprivations for the inebriates in meeting their basic emotional, social, and psychological needs. Thus, the sense of belongingness achieved by membership and acceptance in a social unit larger than the individual himself, such as the family primary group, was only partially achieved by most of the inebriates.

An objective index to evaluate adolescent socialization experience and the significance of these situations for positive identity formation was constructed by the following criteria: (a) participation in a clique or close friendship group of boys, (b) heterosexual participation as reflected in an established dating pattern, (c) existence of goals and aspirations, whether of a middle-class nature or not, (d) family integration as reflected in the individual's sense of belonging to the family unit, and (e) positive school adaptation as reflected in attendance and performance. If all these factors were found in a case, the socialization experience was scored as good or above average; four present was scored adequate or average, and three or fewer was rated as poor or below what would be desired in socialization. The results of these classifications indicated that the symptoms which warn of difficulties in assuming adult social roles are already present in these men at the end of the adolescent development era. By the index of adolescent adjustment, 86 per cent of our sample was rated poor; only 10 per cent could be rated adequate or average, while in 4 per cent the index could not be applied because of incomplete data. In only one case were all five factors present.

Thus the chronic drunkenness offenders are marked by difficult early socialization experiences in their original families and the adolescent sphere of development. This deficit is reflected in the adult inebriate career by the inability to perform two of the most demanding secondary task roles, i.e., occupational and marital roles.

3. Alcohol as the Adjustive Mechanism in the Life Career

The career of the chronic drunkenness offender is one in which drinking serves the socially handicapped individual as a means of adapting to life conditions which are otherwise harsh, insecure, unrewarding, and unproductive of the essentials of human dignity. This type of career is, however, only one of the possible patterns of adjustment, given the combination of conditions in the early life of these men.

Using the age at which a man was committed the second time for public intoxication or a drinking-involved offense as a breakpoint, the study group falls into two types which we shall designate the Early Skid and Late Skid careers.

The Early Skid career pattern involves approximately 50 per cent of the offenders. In this group two-fifths of the men experienced their second incarceration in their twenties and the rest in their early thirties. Only a few had their second imprisonment in the age period 36-39.

The Early Skid career pattern is thus one in which the individual establishes his record of public intoxication in his twenties or early

thirties. It represents serious social and/or psychiatric maladjustment to early adulthood which extends into middle adulthood. There is an absence of adult occupational adjustment independent of institutional living. The period of alcohol dependency formation is not associated with such stable marital adjustment as may be found in some of the Late Skid career patterns.

The Late Skid career pattern is defined by the postponement of the minimum record of two incarcerations for public intoxication until the forties or even fifties. This career type encompasses 50 per cent of the men in the group, if the age 37 (for experiencing the second arrest) is used as the dividing point.

This period of alcohol dependency development is often marked by extended periods of occupational and family stability. Since this period is accompanied by drinking, it must be regarded as part of the conditioning period of alcohol dependency. More apparent in the Late Skid career is the physical decline of the man who is having great difficulty in maintaining his economic stability through marginal types of employment. Younger men replace him on the casual day-labor jobs. His drinking increases and finally his tolerance for alcohol declines.

In summary, the Early Skid career pattern is one in which drinking serves as the primary means of adjustment to original social and/or psychiatric disability; whereas the Late Skid career pattern is related to failure in secondary role performance.

Summary

The conclusions from the Pittman-Gordon study on the chronic drunkenness offender from Skid Row are to a large extent able to be generalized to the homeless population from the same area. This offender is the product of limited social environment and has rarely attained more than a minimum of integration in society. He currently is or has always been at the bottom of the socioeconomic ladder; he is isolated, uprooted, unattached, disorganized, demoralized, and homeless; it is in this context that he drinks to excess. As such, admittedly through his own behavior, he is the least respected member of the community and his treatment by the community has at best been negative and expedient.

In all fairness, however, it should be pointed out that in the last four years certain pioneer rehabilitation efforts have been started. These include the establishment of Half-Way Houses to bridge the gap between institutional and Skid Row living on one hand and independent existence in the community on the other, and the demonstration project on the rehabilitation of Skid Row alcoholic men conducted by the Volunteers of America of Los Angeles in that city.

On the whole, however, the homeless man has never attained or else has lost the necessary respect and sense of human dignity on which any successful program of treatment and rehabilitation must be based. He is captive in a sequence of lack or loss of self-esteem, producing behavior which causes him to be further disesteemed. Thus, any therapeutic program directed to the homeless man must interrupt this cycle in the individual.

But as a sociologist my orientation is guided by the statement: "It is better to prevent than to salvage and repair."

This means that research must proceed on the level of determining what social and economic factors in American society contribute to the development of Skid Row areas and the phenomenon of homelessness

in individuals. Unfortunately, at this time the first question can be answered only in terms of speculation, whereas we have more empirical data relating to socioeconomic correlates of homelessness in individual cases.

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Just let the program grow in you. You can't make the corn come up faster by pulling on the stalks.

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AA's 12th ALBERTA CONFERENCE BIG SUCCESS

Edmonton's Golden Jubilee Auditorium provided the setting for the Twelfth Annual Provincial Conference of Alcoholics Anonymous. Covering a three-day period—March 8th, 9th, and 10th—the Conference was a notable success, with over 800 persons from every part of Alberta in attendance.

On Friday evening, March 8th, an open meeting in the Jubilee Auditorium's spacious Social Room marked the formal start of the Conference. The Provincial G.S.R. meeting was held in the Club Room the following morning and the day's activities were crowned by an evening banquet and dance. Sunday was devoted to a series of open meetings from 10:30 a.m. until 8 p.m.

The exceptionally full attendance was a source of much satisfaction to all, and for many, especially from the extreme north and south of the province, the conference provided the only opportunity they'd had to meet since the 1962 Conference in Calgary.

FOUNDATION MARKS GROWTH OF CALGARY CLINIC

The new addition to the Calgary Centre of The Alcoholism Foundation of Alberta was officially opened on January 31st, at a ceremony chaired by J. P. Matheson, Director of the Calgary unit. Leading participants were The Foundation's Honorary Board Chairman, the Honorable Dr. J. Donovan Ross, Provincial Minister of Health, Board President Mr. Murray E. Stewart, Vice-President of Northwestern Utilities, and Mr. J. George Strachan, Provincial Executive Director of the organization since its inception in 1953.

Individuals and organizations interested in the work of The Foundation attending the opening ceremonies, and the informal reception which followed, included representatives of the provincial government, the medical professions, health and welfare agencies, hospitals, education, commerce and industry, labour and Alcoholics Anonymous.

Covered by Calgary press, radio and television, the afternoon event was attended by Foundation Board members and more than 40 guests. Board members present were Vice-Presidents Mr. R. W. Burns and Mr. George L. Crawford, Honorary Secretary, Mrs. C. R. Wood, M.L.A., Honorable Norman A. Willmore, Mr. George Russell, Dr. R. M. Parsons and Dr. S. B. Thorson. Mayor Harry W. Hays was represented by Alderman Ted Duncan.

Calgary centre personnel, as hosts, welcomed the visitors. After introductory remarks by Mr. Matheson, the gathering heard the history of the Calgary branch and an outline of the general development of The Alcoholism Foundation of Alberta, given by Mr. Strachan.

Dr. Ross and Mr. Stewart both paid tribute to the administration and staff of The Foundation for making possible an outstanding and widely recognized level of service to the province in both the treatment of alcoholism and in the fields of education and research. Speaking for the Board of Directors, Mr. Stewart dealt with Foundation activities, goals and philosophy.

Government and community support, the cooperation of other public service agencies and the growing interest of industrial organizations, were also cited as important contributing factors to The Foundation's progress.

The Alcoholism Foundation of Alberta provides professional services on a provincial scale, with out-patient counselling facilities, information centres and administrative offices in Edmonton and Calgary. Information and referral centers with clinical services are also operated by The Foundation at Lethbridge, Medicine Hat, Red Deer, Westlock and Grande Prairie.

Employing a medical and general social science approach in its treatment program, The Foundation employs a staff of 45 persons. Included in this personnel are medical doctors, consulting psychiatrists, nurses, psychologists, social workers, education specialists and researchers. Financed largely by the provincial government, The Alcoholism Foundation of Alberta also receives contributing support from the United Community Funds of Edmonton and Calgary, some municipal grants, and corporate and private donations.

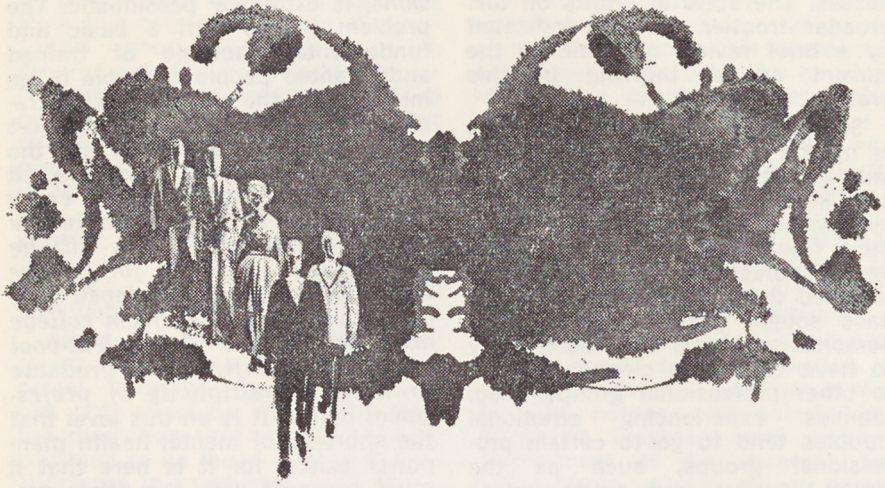
The Calgary center was initially opened in October, 1954, and the new addition was made to the existing building by the Alberta Department of Public Works. The new wing provides the Calgary clinic with a sorely needed additional working area consisting of counsellors' offices and lecture rooms for patient group therapy.

In addition to treatment, The Alcoholism Foundation of Alberta carries on expanding educational services at both professional and general public levels, and research, from their administrative headquarters for the province at 9929 - 103rd Street, Edmonton. The treatment clinic in Edmonton is located at 9910 - 103rd Street.

—Editor

WHO IS AN ALCOHOLISM THERAPIST?

by Daniel J. Anderson



The following article is an extract from the paper delivered by Mr. Dan Anderson to the 13th Annual Meeting of the North American Association of Alcoholism Programs in Bismarck, North Dakota, in October of 1962. An outstanding personality in the alcoholism treatment field, Mr. Anderson is Executive Vice-President of the Hazelden Foundation, Center City, Minnesota.

I FEEL that anyone working in any area of alcohol problems is pioneering on an ill-defined frontier fraught with sufficient controversial concepts and attitudes to last for several lifetimes. To spell out some of them at this time may do little more than increase an already heavy load of conflict without clarifying either the original problems or the additional ones presented for analysis. However, it may be of some value to indicate certain of the key controversial problems that make it so difficult to answer the rhetorical, yet immediately urgent and practical question of *"Who is an Alcoholism Therapist?"*

On a theoretical level one might immediately suggest that the issue in answering such a question is directly related to our concept of *'alcoholism'* and what the word *'therapy'* means in terms of the condition. While we cannot answer this question directly, we do know that alcoholism is a disorder of some kind broadly conceived of as a psychiatric condition. Further, our ways of approaching and understanding alcoholism have followed the philosophy and techniques of treatment used with psychiatric disorders in general. Thus, perhaps we should first turn to the experts in the field of mental, emotional, and personality illness for guidance in coming to grips with our question. Expressed another way, intervention in alcoholism may be better understood if we can ob-

tain principles or practices of procedure already clarified or standardized in related or similar illnesses. The state of affairs on this broader frontier may be indicated by a brief review of some of the current critical thinking in this area.

Several studies of the prevalence of mental disorder have found that only a small portion of the persons with seriously impairing psychiatric symptoms actually receive treatment from members of the mental health professions. It has also been reported that those Americans who have sought professional help for personal problems are more likely to have turned to clergymen than to other professional groups. Also, families experiencing emotional troubles tend to go to certain professional groups, such as the clergy, lawyers and police before seeking psychiatric aid. Such groups, it has been suggested, are important 'gatekeepers' to mental health services. Depending upon a number of factors, such lay appraisals of abnormal behavior may be viewed as a control center through which certain deviant individuals, but not others, are passed along for formal diagnosis and professional treatment. Hollingshead and Redlich have pointed out that we are barely beginning to understand these selective processes and the values upon which they are based.

The question obviously arises 'what happens to the hundreds of thousands of mentally or emotionally disturbed people who do not receive formal psychiatric treatment?' We do not know; we assume that they rely on their own inner resources and/or the help of friends. The next question that might be asked is 'what would happen if the gatekeepers would refer *all* mentally or emotionally disturbed persons for formal psychiatric treatment?'

The answer to our second question, in terms of present manpower trends in the mental health professions, is extremely pessimistic. The problem begins with a basic and fundamental shortage of trained and talented people available to go into any of the professions. Extrapolating from Dael Wolfle's report concerning the utilization of the nation's intellectual resources, it may be pointed out that *for every one hundred children born in the United States only thirty will be intellectually qualified for college work. Of these, only eleven will actually be graduated from college and become part of a talent-pool of persons qualified to do graduate work on a multiplicity of professional levels.* It is on this level that the shortage of mental health manpower exists, for it is here that it must compete with the other professions for the intellectual talents developed by only 11% of our population.

In summarizing their evaluation of the mental health manpower shortage in the fields of psychiatry, psychology and social work, Albee and Dickey have this to say: "We believe that there is wholehearted unanimity among knowledgeable people about the staggering dimensions of the mental health needs of the nation. From whatever viewpoint, be it humanitarian, economic, or scientific, mental disorder is far and away our number one health problem. It is real, it is now, and it will not go away. It will only get worse."

"Everyone who is aware of the problem agrees that the need for trained professional personnel in the mental health field is desperate. The stark reality is that we cannot even keep up present numbers in proportion to the population. We have not found a single optimistic voice. Occasionally someone suggests a crash program with recruiting drives, pub-

licity, subsidized training, and special inducements to lure more students into the training programs. If the mental health professions were the only ones where the personnel shortages existed, such programs might be effective in increasing our output of trained people a few years hence. But shortages are not specific to our own fields, they are part of a more pervading shortage of scientific and professional personnel in general. Our pessimistic facts are duplicated in the shortages of teachers, nurses, engineers and scientists."

Albee and Dickey conclude their review of the mental health manpower shortage by stating: "We can only conclude this survey with the prediction that our country will continue to be faced with personnel shortages in psychiatry, psychology, and social work for years to come. Barring the possibility of a massive national effort in all areas of education, or the possibility of a sharp break-through on mental health research, the prospects are pessimistic for improvements in the quantity or quality of service in the field of mental health."

Even the simple question of whether the mentally ill person is *unable* or *unwilling* to get well is currently being debated in the mental health literature. The presumably dead issue of whether behavior pathology should be looked upon as 'sin' or 'disease' is still being questioned. So, too, is our present use of the very concept of 'disease' being questioned.

In what has come to be known as the Szasz-Mowrer position, certain of the above questions have been seriously debated. Some of the specific issues under fire may be stated as follows:

In our traditional concept of disease only symptoms of disturbance resulting from demonstrable physical lesions qualify as legitimate manifestations of disease. In this traditional sense mental symptoms must have some definite neurological basis. Under no circumstances, therefore, can mental symptoms without this demonstrable neurological basis be considered a form of illness. Presumably, physical symptoms are objective in nature, and are ascertainable without personal involvement of the observer and are independent of cultural norms and ethical standards. Only mental symptoms possessing these characteristics are genuinely reflective of illness and amenable to medical treatment.

From this point of view, physical illness is in contra-distinction to mental symptoms which are subjective in nature, dependent upon subjective judgment and personal involvement of the observer, and referrable to cultural, ethical norms. Such mental symptoms are expressions of problems of living and hence, cannot be regarded as manifestations of a pathological condition. Thus, the concept of mental illness is misleading and illogical because it seeks to explain psychological disturbances in particular, and human disharmony in general, in terms of a non-existent physical disease entity, instead of attributing them to inherent difficulties in coming to grips with illusive human problems of choice and responsibility. Szasz, who holds the above position, thus feels that *'the concept of mental illness now functions merely as a convenient myth.'*

Mental ill health is a negative concept involving negative attitudes, feelings, and behavior of which there is little agreement as to classification, and cause and effect relationships. Therefore, one might think that by shifting over to *'normal'* behavior that we would be in better company in terms of clarification of concepts. But here again we find the same difficulty:

namely, the inability to define adequately or to conceptualize to our satisfaction what we mean by the term *'normal.'*

Does 'normality' or 'integrated behavior' or 'mental health' reflect nothing more than a minimum degree of pathology? Perhaps the positive aspects of human development have merit in their own right. When Shoben considers the main socializing forces in society the family, the church and the school, he cannot believe that they exist simply to minimize inevitable pathological traits in the developing members of the community. Rather, he feels that their function is that of facilitating some kind of growth; the progressive acquisition of those characteristics, skills, knowledge and attitudes which permit or encourage more productive, more satisfying ways of life. In fact, Shoben believes that what we call mental illness or sickness may be better understood if we were to conceive of it as maladjustive behavior patterns which are ineffective and defensive styles of life. Such an attitude reflects the growing tendency to conceptualize mental health as emphasizing positive development of personality with the prevention and treatment of pathology regarded as an important but a secondary factor.

Obviously the problem is one of values. It is here, of course, that natural scientists, humanists, theologians, and all of the rest of us have our greatest controversy. And it is this area of values, both relative and absolute, that the scientist has not yet learned to evaluate. In fact, on the level of behavioral science, he seemingly has attempted to avoid making value judgments. Yet, it is becoming increasingly apparent that this position is one which also is based on values of some kind. And it is at this point that the behavioral sciences and ethics do meet and merge, and one's behavior, whether he wishes it or not, takes on a moral, ethical aspect. The very fact that psychotherapy endeavors to make unhappy, and unproductive people able to lead more meaningful, more useful and more satisfying lives is a statement which in itself indicates a highly ethical perspective. It is this increasing awareness of the evaluative relationship between mental health and mental illness that is bringing a re-examination of the relationships between religion and mental health. And it is at this juncture that historians have noted that there was a time when religion and healing were but a single discipline, a time when sin and disease were equated.

Lest it be thought that we might lose contact with the field of mental illness, let us remember that the Mental Health Educators are now examining critically their practice of telling the public that mental illness is the same as physical illness. The public knows it is not the same. Our attempts to suggest that alcoholism can be equated with either physical and mental illness may also need a second look. The public knows that alcoholism is quite different from both of these conditions—and that the techniques of intervention may be different.

Just one more general problem and then we will move on specifically to the field of alcoholism. This problem concerns the nature of psychotherapy. Since, somehow, the alcoholism therapist must practice some kind of therapy or counselling, we must ask what is the nature of this relationship. *In the final analysis perhaps psychotherapy is essentially little more than a significant human relationship.* Unfortunately, it is a relationship that is, as yet, not accessible to scientific verification. As Frank recently reminded us, we are still unable to describe pa-

tients, therapies, or improvement in terms that permit valid comparison of the effects of different therapies, on the same class of patients. He points out that there is very little experimental evidence to show that psychotherapy works at all, or that one existing form of psychotherapy is superior to any other.

It is readily apparent from Frank's work and the work of several other investigators that the issue of psycho-therapeutic effectiveness still remains to be scientifically demonstrated. By way of example, most studies of psychotherapeutic effectiveness tend in general to yield disappointing findings. More refined techniques of measurement have not as yet been adequately developed. We lack adequate criteria of improvement. We do not know which ingredients in the therapeutic technique are effective and which are inert. We do not know what part is played by the personality and the attitudes of the therapist. We do not know what cultural factors effect the therapeutic process.

And perhaps most difficult of all we do not know how to measure the subtle interactions which take place between therapist and patient behind which, hiding from scientific scrutiny, lies the real meaning of this significant human relationship. I personally am inclined to agree with Frank who feels that psychotherapy works, when it works, for those who expect it to work. Also, the effect of successful psychotherapy may be that of facilitating or accelerating healing processes that might go on, in its absence, though more slowly. Also, this or that form of psychotherapy may work but not for the reasons put forth by its proponents. Further, when any form of inter-personal therapeutic relationship is successful, its success may be due to its similarities to, rather than its differences from, other modes of therapy. I would agree also that the various techniques of psychotherapy proposed, no matter how wild, probably persist simply because they do some good or otherwise they would disappear.

Now just what is the point of this general review of the state of affairs on this broader frontier of behavior pathology? It is this: in the field of alcoholism we are confronted with the overwhelming problem of developing procedures and techniques for dealing effectively with the alcoholic in producing behavioral change. But when we turn to other areas of behavior pathology for guidance we find that:

1. There is a tremendous shortage of professionally trained mental health personnel to do the job.
2. The shortage will continue for an indefinite period in view of the limited help available in the pool of trained and eligible personnel.
3. Thousands of disturbed people must find some help for themselves through non-professional resources.
4. Even if more trained therapists or mental health practitioners were available our conceptualizations of mental, emotional, and personality illness are very inadequately understood.
5. Our concept of 'normal' lacks adequate definition.
6. The concept of mental health is poorly defined.
7. The problem of values and criteria for making value judgments appears to be a major source of our difficulty in relating mental illness and health on a meaningful continuum.
8. Psychotherapy, the principal technique of intervention in

mental illness, is not yet accessible to scientific verification as a useful treatment technique.

Again what is the point of this review of certain of the crucial problems which continue to plague the behavior pathologist? Perhaps the point is simply that there is no Santa Claus. There is no one to hold our hand as we try to solve the riddle of alcoholism. Every single one of the problems mentioned with respect to intervention in behavior pathology in general applies with equal or even greater rigor to intervention in alcoholism.

Despite the many assaults made on it by various interested groups —including medicine, psychiatry, psychology, sociology, the clergy, the layman, and even alcoholics themselves—alcoholism, its cause and effective treatment, still remains one of the major and unanswered problems of our time. I am inclined to agree with those who hold that the problem is one which is less likely to yield to heroic measures than one which may eventually be solved to a degree by a slow working away at one or more of the many factors that produce or perpetuate it.

In an immediate, practical, expedient sense, perhaps our best approach is to continue to do deliberately what we actually have been doing intuitively: namely, actively assist in the emerging professionalization of the field of alcoholism.

It is within our power to decide who an alcoholism therapist should be simply be setting up at least some of the basic credentials required for adequate specialized functioning on this level. Literally, what we need are accredited schools for training alcoholism counsellors.

Who should be accepted for training? In view of the foregoing discussion of the professional manpower shortage and the accompanying emergence of the 'Alcoholism Therapist,' perhaps all we can and should do is accept our various working alcoholism therapists and continue deliberately to integrate them into a well-trained experienced professional team capable of intervening on any treatment level in alcoholism. That these people can be integrated into an effective team is evidenced by the fact that our stereotype of the various alcoholism experts increasingly lacks validity as these therapists of various levels and kinds of training demonstrate increasing ability to communicate with and understand each other's philosophical position, and techniques and goals of intervention.

What will be some of the identifying marks of this alcoholism therapist? We could speculate considerably about the kind and extent of training required and advisable, but time does not permit this. Let me close by suggesting very tentatively some of the probable identifying characteristics of this 'Alcoholism Therapist.'

His counselling probably will not follow classical lines.

He may treat symptoms.

He may be quite directive, at times.

He will encourage the development of a spiritual value system.

He will be concerned with characterological aspects of personality.

He will fear dependency on drugs other than alcohol.

He will directly communicate positive Mental Health principles as they apply to the alcoholic.

He will encourage small peer-group therapy sessions as perhaps being better than individual treatment, based on alcoholism findings, not mental illness findings.

He will steer a middle course between each alcoholic's inability versus his apparent unwillingness to get well.

He will be acutely aware that he does not know the cause of alcoholism but does know something about the principles and techniques of helping the alcoholic to find a positive way of life that will encourage him to go without alcohol at least for today.

He will encourage AA affiliation as a sustaining program.

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A ship should not ride on a single anchor, nor life on a single hope. —*Epictetus.*

In taking the Fifth Step with an understanding (and close-mouthed) friend, don't shilly-shally. Plunge right in, worst things first.

A.F.A. PREPARING TENTH ANNUAL GENERAL MEETING

It is expected that the Tenth Annual General Meeting of The Alcoholism Foundation of Alberta will be held in Edmonton on May 29th. Confirmation of this schedule may be obtained by contacting The Foundation's administrative offices in Edmonton.

A. W. FRASER

Effective March 31st, 1963, Allon W. Fraser, Director, Treatment Services for The Alcoholism Foundation of Alberta since 1953, will enter practice with a firm of industrial and personnel consultants. Mr. Fraser's contribution to the development of staff and program at The Foundation has been outstanding. Not only has he received wide recognition in the province, but those in the field of alcoholism generally will sorely miss his counsel. Despite the loss of a valued and respected friend, the Board, Executive Director and Staff of The Foundation wish to extend their sincere wishes for Mr. Fraser's continued success.

DIALYSIS - - A Life-Saving Procedure In Severe Alcohol Poisoning

"HE IS DEAD DRUNK, let him sleep it off," is one way of treating the comatose intoxicated patient. Another is to give supportive measures to ease breathing and stimulate blood circulation. Fluids may be administered, cardiac stimulants and vitamins. But sometimes, when the patient has a near-lethal concentration of alcohol in his blood, these measures are not enough.

A new and heroic treatment, suggested by J. Marc-Aurele and G. E. Schreiner, (Washington, D.C.) is to use the artificial kidney to rid the organism of massive doses of alcohol, ethyl or methyl. They tried this method at first in the test tube and then in dogs.

In the experiment with dogs, up to 6 ml. of ethyl alcohol per kg. of body weight, or up to 5 ml. of methyl alcohol per kg., was injected by vein. Blood was then diverted from a femoral artery into a saline dialysis bath, and returned to the body through the adjacent femoral vein. The bath volume was 50 liters for ethyl alcohol and 100 liters for methyl alcohol, and the average rate of flow was 150 ml. per minute. Each dog was dialyzed in this way for 3 hours and the blood alcohol concentrations in these dogs were compared with those in animals which received the same doses but were not dialyzed.

The results were gratifying: a blood alcohol concentration of 0.519 per cent dropped to 0.178 per cent in 3 hours of dialysis, a reduction of about two-thirds, while in the control dogs the concentration dropped only one-sixth or less. In the case of methyl alcohol, the difference in removal of alcohol from the blood was even greater.

The experimenters calculated that a 3-hour dialysis removed ethyl alcohol from the organism about 4 times as fast as does the normal physiological process. In the case of methyl alcohol the removal by dialysis was 22 times as fast. The non-dialyzed dogs which had received ethyl alcohol remained unconscious throughout the 10 hours of the experiment while the dialyzed dogs awoke by the second hour. All the non-dialyzed dogs which received methyl alcohol remained blind and were unable to stand for 24 hours after treatment. The dialyzed dogs were alert at the end of the experiment.

Marc-Aurele and Schreiner concluded that they have demonstrated a rational basis for the use of dialysis in massive alcohol poisoning. They believe that early action with the artificial kidney can save lives and, in the case of methyl alcohol poisoning, prevent blindness.

The principle of dialysis, though with a different technique, was actually used by B. J. Stinebaugh (Canal Zone) in three cases of methyl alcohol poisoning. Stinebaugh did not use the artificial kidney outside the body for dialysis; instead, he introduced the saline with 5-per-cent glucose directly into the peritoneal cavity, so that dialysis took place between the intestines and the saline. Three liters of the fluid was allowed to remain in

the body for 2 hours and was then drained. The procedure was repeated after drainage. With each successive drainage the concentration of methyl alcohol in the dialysis fluid was reduced and in two of the three patients became negative after 24 hours.

The precise effect of the dialysis on the course of the poisoning could not be determined because all three patients received adequate alkaline therapy, but this trial showed the feasibility of removing alcohol from the body by dialysis. Stinebaugh concludes that in severe methyl alcohol poisoning three measures are essential: Alkalinization to combat acidosis; administration of ethyl alcohol to prevent the oxidation of methyl alcohol; and dialysis for the removal of the poison.

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ALCOHOL STUDY GROUPS TO CONTINUE AND EXPAND IN 1963

Interest in alcohol studies among members of professional, lay and public administrative groups is growing steadily as the wide involvements of acohol and alcoholism become more and more clearly delineated against the social fabric of both our community and our national life.

Under the joint sponsorship of the University of Alberta, Department of Extension, and the Alcoholism Foundation, Alberta held well-attended conferences on alcohol studies in 1954-55-56. These featured lectures by leading Canadian and U.S. authorities in the alcoholism field.

In 1963, a number of seminars are planned for the early Fall, including workshops for such special groups as clergy, medicine, industry, health and welfare agency staff, and other Provincial bodies.

To keep The Foundation abreast of new developments in the field of alcoholism, staff members will be attending such outstanding Summer Schools of Alcohol Studies as those at Columbia, Rutgers, Toronto, and Utah Universities.

The Western Canada School of Alcohol and Narcotic Education, (formerly the Alberta, Saskatchewan, Manitoba School) is slated for this summer in Saskatoon, with A.F.A. personnel participating.

Interested persons are encouraged to write to those centres or to The Foundation for further information.

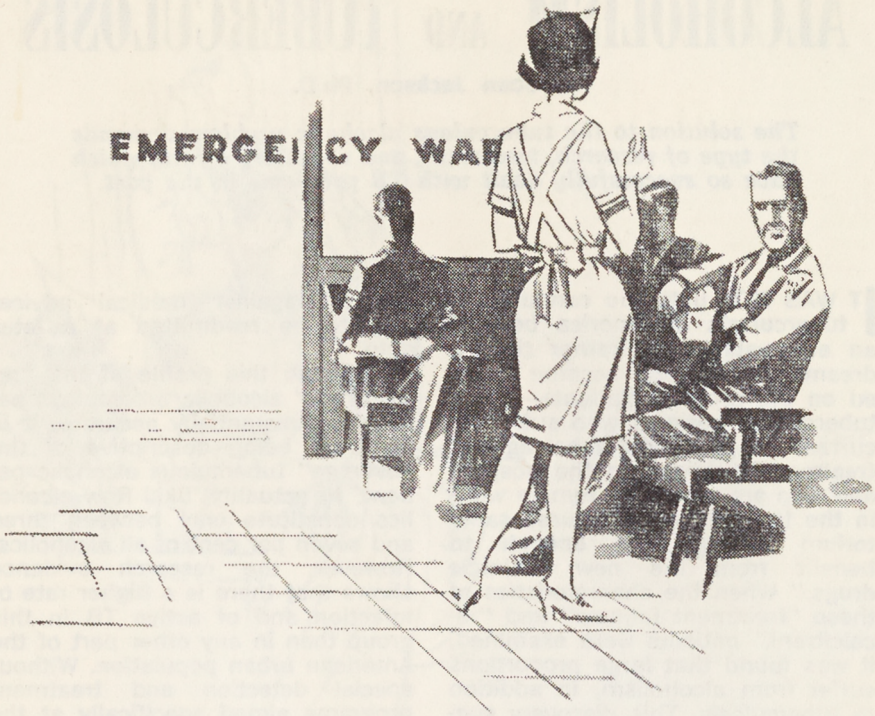
MOTIVATING THE ALCOHOLIC TO COME FOR TREATMENT

IT HAS BEEN said again and again that the alcoholic can be treated with success only if he sincerely wishes to get well; this statement has given grounds to many a therapist to wash his hands and declare that there is nothing he can do with an unwilling patient. Others, however, have taken a different attitude toward professional obligations. They recognize that it is up to the helping teams—that is, the clinics, the hospitals, the therapists—to see to it that the alcoholic is led to desire help and to accept it. The vital question is how to go about getting the patient to realize his need for help and treatment. Little is known about the process which causes the alcoholic to seek help and this lack of knowledge has, naturally, hampered the efforts to bring him to treatment.

One way of tackling this problem has been described by M. Brunner-Orne (Boston). Informal group sessions are held with emergency-ward patients, alcoholics who are admitted to the New England Hospital (Roxbury, Mass.) for short periods of hospitalization which average about 10 days. In this brief time it is not possible to initiate real treatment. Most emergency-ward patients are unable to accept the idea that they need treatment; and, besides, they rarely understand what a psychiatrist can do. The goal of the informal group sessions, held right on the ward, is mainly to enable the alcoholic to recognize his need for help and to establish a positive attitude toward more definitive future treatment. Discussion of common problems allows a rapid formation of relationships with others who share the same problem; and psychiatric treatment is more easily accepted once the patient learns that the psychiatrist can help with immediate and pressing problems.

Another way of motivating the alcoholic to return for treatment is described by M. E. Chafetz (Boston). The logical place to establish a therapeutic relationship with the alcoholic, he notes, is in the emergency ward, where many more alcoholics are admitted than ever come to the rehabilitative clinic. Here, also, the alcoholic is at his most vulnerable, for when he comes for emergency medical or surgical attention, his dependency needs are greatest. Instead of the fragmentary relationship with the admitting clerk, a social worker, or a resident—the usual procedure in hospital emergency wards—the alcoholic should be seen by a psychiatrist interested in establishing a therapeutic relationship and inducing him to participate in the rehabilitative program at the clinic. In addition, a psychiatric social worker should be assigned to see to his needs outside the hospital and to offer him and his family help in their social setting.

To test these ideas, starting on a certain date, every alternate alcoholic patient admitted to the emergency ward at Massachusetts General Hospital was assigned to a control or an experimental group. The former were treated in the routine manner as previously, while the latter were seen by the psychiatrist and the psychiatric social worker. Chafetz reports that 42 per cent of the first 40 patients treated in the experimental way made the initial follow-up visit to the clinic, and 20 per cent then made 5 or more vol-



untary clinic visits. By comparison, less than 1 per cent of the routinely handled patients came to the clinic and not one of them made as many as 5 subsequent visits.

The patients on the emergency ward came from a much lower socio-economic level than the regular clinic patients. Many were physically collapsed homeless men suffering from the severest degree of alcoholism. Yet the number of therapeutic contacts made by these experimental patients was comparable to that achieved by the regular clinic population.

These hopeful results indicate that conditions can be created which will permit the alcoholic to involve himself in treatment, and that a therapeutic milieu can be developed from which he will not shrink. Such a milieu must include trained personnel as well as medical and social provisions. The study also suggests that when the alcoholic fails to seek out treatment or fails to stay with it, the fault is not his alone. The caretaking community should recognize its own failure to develop methods of establishing therapeutic relationships with him.

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ALCOHOLISM AND TUBERCULOSIS

by Joan Jackson, Ph.D.

The solution to the tuberculous alcoholic problem demands the type of research, treatment, and voluntary efforts which have so successfully dealt with TB problems in the past.

IT WAS NOT until the conquest of tuberculosis in America became an achievable goal, rather than a dream, that attenion became focused on the **problem patients**—those tuberculosis patients who suffer recurrent relapses, who rebel against treatment regimens in the hospital and who are unable to remain within the traditionally structured sanatorium setting long enough to benefit from the new "miracle drugs." When the characteristics of these "treatment failures" and "recalcitrant" patients were examined, it was found that large proportions suffer from alcoholism, in addition to tuberculosis. This discovery suggested that the prevention of alcoholism might be an important aspect of tuberculosis prevention and that the successful treatment of tuberculosis in an alcoholic tuberculous patient is probably dependent upon the successful treatment of his alcoholism.

The profile of the tuberculous alcoholic patient which emerged is of an older, homeless male who has been highly mobile occupationally and residentially for many years. He has been jailed frequently for offenses directly related to excessive drinking. In the hospital he finds it difficult to accept the diagnosis of tuberculosis and impossible to accept the diagnosis of alcoholism. He often refuses to be hospitalized for his tuberculosis. If he is cajoled or forced into a sanatorium, his behavior brings staff disciplinary action; on occasion he refuses to accept treatment; he often leaves the hospital against medical advice, only to be readmitted at a later date.

Although this profile of the "recalcitrant" alcoholic tuberculous patient is substantially accurate, it is far from being descriptive of the "average" tuberculous alcoholic patient. In actuality, Skid Row alcoholics constitute only between three and seven per cent of all alcoholics. However, the research evidence shows that there is a higher rate of infection and of active TB in this group than in any other part of the American urban population. Without special detection and treatment programs aimed specifically at the Skid Row tuberculous alcoholic, his illness is not likely to be diagnosed; he is not likely to comply with the prolonged hospitalization and course of treatment necessary to cure or arrest tuberculosis. Higher than normal proportions of such patients will be found in sanatorium populations only in those states which have detection techniques reaching into city jails, missions, and county hospitals, and which strictly enforce quarantine laws. In many states, therefore, alcoholic patients hospitalized for tuberculosis tend to be from the same cross sections of the community as the non-alcoholic ones. Moreover, they are infrequently diagnosed as alcoholics, since they do not come to the hospital from Skid Row or otherwise match the profile.

It is unfortunate that awareness of the problem of alcoholism as a complication in the treatment of

tuberculosis arose from the study of "recalcitrant" patients. Partly as a result of this study, "alcoholic" and "recalcitrant" have come to be used as synonyms. Consequently, blinkers have been placed on our perceptions of possible solutions for the types of problems in which tuberculous alcoholic patients become involved. For example, when the Skid Row alcoholic or recalcitrant patient profile is used as a diagnostic criterion for alcoholism—which is only too often the case—it is impossible to recognize those alcoholics in the sanatorium who are "good" patients and "treatment successes." Thus, the knowledge to be gained from "good" patients, who are also alcoholic, regarding the factors which go into the comfortable hospital adjustment of some alcoholic tuberculous patients, and into their recovery from tuberculosis despite alcoholism, is lost.

With this background, it is not difficult to see why most hospital staff members continue to react toward all tuberculous alcoholic patients on the basis of their experiences with those who are also "recalcitrant," not realizing that these represent only a small segment of the total tuberculous alcoholic population in the sanitorium. Negative staff attitudes toward tuberculous alcoholics are likely to help cause recalcitrant behavior, as well as result from it. Such attitudes may cause patients to leave the sanatorium or otherwise interrupt their treatment; the research evidence is strong on this point. These occurrences might be less frequent if staff members could be shown the total picture. It is obvious that

the so-called problem of the alcoholic tuberculous patient continues to appear more hopeless than it really is.

The only way out of the impasse is to take a new look at the total situation and to change some of our diagnostic and treatment techniques. There is a sizable body of scientific literature on alcoholism on which such a new approach can be based.

The diagnosis of alcoholism must be divorced from any consideration of the patient's behavior in the hospital and his previous social adjustment. A number of studies have shown that alcoholism, like any other disorder, can be diagnosed by drinking patterns and by a predictable symptom progression. To be sure, the tests for alcoholism do not have the concreteness of an X-ray or culture, but they are efficient in differentiating alcoholics from non-alcoholics, and in defining the stage of alcoholism as early, moderately or far advanced, or chronic. The symptomatology of alcoholism was described as early as 1946, and progression of symptoms has been delineated since 1952. However, those who deal with tuberculosis patients tend to be unaware of these criteria for diagnosis and of the extensive literature on alcoholism. Diagnosis is still based on folk beliefs about the quantity and frequency of drinking, on behavior in the hospital, and on the Skid Row profile, rather than on scientific knowledge.

The treatment of alcoholism in the sanatorium, in the few places where treatment is given, also has tended to rely on folk knowledge. When the alcoholic tuberculous patient is admitted to the hospital, the major concern of the staff is with his tuberculosis. His drinking problems tend to be overlooked until an episode of drinking or recalcitrant behavior occurs. It is assumed that as long as he is not drinking, he is not suffering from alcoholism. It might just as well be assumed that if he is not coughing he does not have TB.

If treatment of alcoholism waits on a recurrence of drinking, it is often too late. The Skid Row patient, in particular, is not likely to be around to be treated, having a drinking pattern which involves an extensive web of social relationships not to be found within the hospital walls. Even if the alcoholic patient remains in the hospital, the doctors and the nurses have a difficult time handling the aggravation of his drinking symptoms and an equally difficult time handling upsets of other patients, of hospital routines, and of their own feelings about the episode.

Although the hypothesis remains untested as yet, our knowledge of the relationships between tuberculosis and alcoholism has led to the belief that treatment of alcoholism must begin at the same time as treatment of tuberculosis and, to be successful, must parallel it throughout the hospital stay. While it would be ideal to have the ward physician treat both alcoholism and tuberculosis, at the present time this is impractical. However, in most communities there are agencies which treat alcoholism and which could help set up treatment programs for the alcoholic tuberculous patient. In addition, Alcoholics Anonymous members are willing to help alcoholics wherever they are to be found. Thus treatment within the sanatorium is not an unachievable dream.

If such community treatment facilities are to be used with any success, however, they must have the understanding and support of the sanatorium staff and the members of voluntary associations concerned with tuberculosis. The doctor and nurse must be in favor of the treatment programs and know how to present them to the patient

in an acceptable manner. The voluntary association will be asked to interpret the program to the community and, perhaps, to provide volunteers and funds for aspects of the program. All of this means that everyone involved will be asked to invest a large block of time in already crowded schedules to learning about alcoholism and about its treatment. This cannot occur until there is more acceptance of the seriousness and permanence of the joint occurrence of alcoholism and TB.

Alcoholic tuberculous patients will constitute an increasing proportion of patients within the sanatorium in the foreseeable future. This is not due solely to the rising rate of alcoholism in the general population and to the better detection techniques for alcoholism. To a much greater degree, the increasing numbers will be due to changes in the control and treatment of tuberculosis. More emphasis will be placed on detection among groups of the population who are known to have a high rate of infection, and active disease. Moreover, until many of the problems in ensuring adequate treatment to alcoholic patients have been overcome, alcoholic tuberculous patients will accumulate in the hospitals merely because it takes longer to treat their tuberculosis.

It should be remembered that, in this century, the problems of treating tuberculosis were as difficult, and seemed as impossible of solution, as the successful treatment of alcoholism seems today. Tuberculosis victims were stigmatized, just as are our present-day alcoholics. They experienced the same kinds of attitudes from those who treated them and from other members of the communities in which they lived—but because workers in the field of tuberculosis were willing to face these difficulties squarely and act appropriately, the outlook for a world free of tuberculosis is brighter than at any other time in human history.

For those who are interested in the conquest of tuberculosis, alcoholism in tuberculosis patients is a highly important frontier. The solution of the problem demands the type of research, treatment and the voluntary efforts which, in the past, have been so effective in illuminating and successfully dealing with similar problems relating to TB.

Published by permission of the author, this article originally appeared in the Bulletin of the National Tuberculosis Association, and in Inventory. Dr. Jackson is a research associate professor at the University of Washington School of Medicine, Seattle, Wash. She is noted for research studies about the tuberculous alcoholic and family aspects of alcoholism.

I used to call on God when I was in trouble. Now I thank Him when I'm not in trouble.

The program has given me Today. When I was drinking I never had Today. It was always last year or next month or some other time, never Today.

I never made a break with my church but AA has given me something I never had before, the companionship of God.

When an alcoholic finally sobers up and gets the program, his problem is no longer alcohol — his problem is living.

WHY DON'T THEY JOIN AA?

by Dr. Harrison M. Trice

"Why do so many sick alcoholics avoid the therapy that might help them? What can be done to make them more receptive?" These questions, asked wherever drinking is a problem, are taken up by Harrison M. Trice, Ph.D., who is Assistant Professor of Industrial and Labor Relations at Cornell University and an A.A. Trustee.

FOR MORE THAN twenty-five years Alcoholics Anonymous has grown and spread on the American scene. Rarely are treatment activities described without a prominent place being accorded to "AA". It has been eulogized and analyzed, but seldom have its "negative instances" been scrutinized. Emphasis has been placed on what happens after an individual affiliates with it. Only infrequently has attention been given to the question of how affiliation came about in the first place. In the flush of favorable publicity and widespread recognition, one factor in this "group therapy" has been overlooked, namely, the alcoholic who is exposed to affiliation with this group but who, for some reason, "doesn't take to it".

Usually it is maintained that some problem drinkers are "ready" to join while others are not. This immediately raises the question, what constitutes "readiness?"

The available literature indicates a mild awareness of the problem of nonaffiliation, accompanied by incidental hunches as to its explanation. Bill W., one of the co-founders, states that the majority of nonaffiliates "have powerful rationalizations to be broken down." R. Wilson, writing in Mental Hygiene, is baffled by the inability of some to join: "With all the advantages AA offers, one cannot resist speculating on what characterizes those potential recruits who are unable to profit from membership, but offer no explanation."

In the light of this meager literature regarding affiliation, a series of exploratory interviews with both affiliates and nonaffiliates was undertaken by this writer. From three groups in Madison, Milwaukee and Janesville, Wisconsin, a total of 111 members cooperated. Informal discussions with group secretaries indicated that approximately 6 out of 10 members in the cooperating groups responded.

Certain experiences before going to any meetings at all discriminated significantly between affiliates and nonaffiliates. Most prominent of these is self-conception as a person who could share basic emotional reactions with others.

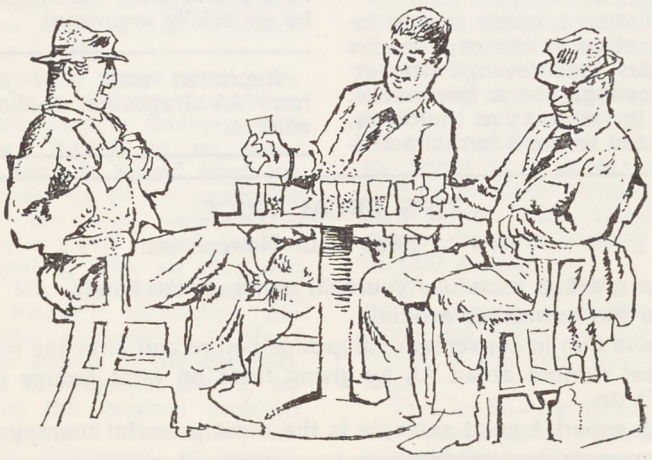
In contrast, nonaffiliates did not perceive themselves as persons who readily shared emotional reactions with others. It is interesting to note that very little discrimination between the two groups existed concerning the self-lable "alcoholic." Apparently many nonaffiliates as well as affiliates applied this term to themselves before ever going to an AA meeting.

Among the various associational experiences recounted by the subjects in the exploratory interviews, three seem to be highly conductive

of affiliation. The absence of a close friend or relative who had quit drinking by his own will power was decidedly influential. The nonaffiliates had a significantly larger number of associations with esteemed friends or relatives who, they thought, had stopped using alcohol by individual volition. Thus, they had a "will power model" in their immediate associational experience that competed strongly with A.A. As one nonaffiliate put it, "One of these days I'll do like my old uncle. One day he threw his bottle down on the floor and swore never to touch another drop, and he didn't." The fact that his "old uncle" may not have been an alcoholic, or may never really have stopped drinking, is beside the point. The nonaffiliate is convinced his model did stop by his own will power. Thus when he comes to AA meetings he says to himself, "This stuff is all right, but why should I get mixed up in something that tells me to give up? One of these days I'll stop by myself like old Uncle Joe." It must be borne in mind, too, that this reaction is highly approved by our society, which places a high premium on individualism, on independent action, on "standing on your own two feet."

A second experience that differentiated between affiliates and nonaffiliates is the fact that the former had, before going to any meetings at all, already lost their drinking friends, while the latter had not. This suggests that the affiliates came from a background in which "symptoms" of alcoholism are readily stigmatized while the nonaffiliates came from social situations in which these manifestations are more readily accepted as "normal."

If, before going to any meetings at all, an alcoholic had been exposed to favorable descriptions of the sincerity of members, his chances of affiliation were increased significantly. Apparently those AA members who quietly and without fanfare live up to the principles of the group create impressions that become a part of favorable "hearsay." This, in turn, was often the precipitating factor that helped a nonmember become a member once he tried to "get on the program." On the other side of the coin, nonaffiliates had been exposed to an excess of hearsay contacts that de-



fined members as "going to meetings and drinking on the side."

At the time of first contact the probability of affiliation is further increased if there is present in the expectations of the alcoholic an accurate conception of what will take place at meetings. In significantly greater proportion, affiliates came from a system of communications that contained accurate descriptions of what AA meetings are actually like, while nonaffiliates had confused expectations; often, in exploratory interviews, they spoke of expecting a similarity to church, expecting more ceremony, more speechmaking, more prayer.

At this time, affiliates experienced a closeness of contact with the receiving group that stood in marked contrast to the experience of the nonaffiliates. Not only were the affiliates sponsored, while the nonaffiliates tended not to be, but the receiving group stayed in closer overall contact with them. In other words, the entire group, or at least large segments of it, were involved in receiving the newcomer.

Coupled with this was an inclination to affiliate that apparently arose from a conviction that life without alcohol could be more satisfactory than life with it.

The affiliation process moves toward completion in the experiences and attitudes that develop after attending meetings for a few weeks. Affiliates, in impressive numbers, were attracted to the informal activities before and after meetings. This made it, compared with nonaffiliates, easy to give up their drinking friends. The therapy of AA is thus revealed as one of informal, spontaneous groupings, centering around a formal base.

Two aspects of family life tended to influence affiliations: the wife and blood relatives. In the case of affiliates, the wife (or girl friend) tended to go to meetings and support what she saw and heard. Nonaffiliates were not so fortunate. Often their wives presented them with a hard choice: drink with the woman you love or abstain with a relatively strange group.

The affiliates were able to accept the spiritual ideas in AA more readily than nonaffiliates, although the difference was not as great as might have been expected.

It seems reasonable for treatment agencies to develop pre-AA group therapy aimed at reducing the barriers.

Specific suggestions to AA groups can also be derived from the findings. The value of sponsorship coupled with a positive approach toward newcomers seems apparent. Specific efforts aimed at including him in the small, informal groupings before and after meetings seem to be especially important.

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TIPS FROM TRICE

How to Keep Your Newcomers:

1. Be a greeter: introduce yourself, smile, shake hands.
2. Take the newcomer around.
3. Involve him in conversational groups before and after the meeting.
4. Dispel rumors about AA by giving facts on what groups do and don't do.
5. Keep sober! A good example is the most powerful therapy.

"DECISION" *

by Gordon A. Wemp

EXECUTIVES of Commerce and Industry are becoming increasingly aware that alcoholism among employees is a very real cost factor. What to do about it is not so well known. Some of the facts were dealt with recently by Mr. J. P. Matheson, Deputy Director, The Alcoholism Foundation of Alberta, Calgary Centre, on a television program titled "Decision".

"Decision", carried by CHCT-TV is produced in cooperation with the Business Development course of Mount Royal College and is sponsored by the Hudson's Bay Company. The program deals with a wide variety of problems found in Commerce and Industry. Each problem requiring a decision is published in advance in the two daily newspapers, and the viewers are invited to submit what they believe to be a good solution to the problem. From the submissions, candidates are selected who can qualify by examination for scholarships to Mount Royal College. The scholarships, provided by the Hudson's Bay Company, are in four categories, two for High School students and two for adults.

The program is of the panel type, conducted by a regular moderator. Various executives of Business and Industry are invited to be panel members. Each is asked what his decision would be in the particular case, and the final decision is rendered by a guest expert. On the program dealing with an alcoholic employee, Mr. Matheson was the "Decision - maker". Following the program, The Foundation received requests for copies of the decision. Because of the interest shown, we reprint here the original problem which called for a "decision", followed by Mr. Matheson's statement.

Case No. 18

I run a large painting and decorating business, employing about 50 men. Five years ago, I hired a general foreman for operations —and he was good. In his first year he cut operating costs considerably. The men seemed to like him—and he was very personable. I figured he was really the man.

Well, two years ago he missed coming to work on Monday. When I phoned his wife she said he'd been called out of town because his mother was sick. I heard he had been in town Saturday night and really drunk. I didn't do anything about it—figured he was entitled to a lapse.

About a year ago—he fired a painter for drinking on the job. The painter made some crack about how come he gets fired when the foreman can be drunk all the time. I ignored this—I really didn't know what to do.

Six months ago—my general foreman missed four days of work and that really caused a mess on the job. I called him in and asked about the drinking. He said he was sorry and that it really wasn't anything to do with the company. He liked working for us and I had to admit that lately he'd been putting in 12 to 14-hour days. By this time, with bonuses and raises, he was making close to $9,000 a year.

Two weeks ago he missed another Monday. I didn't say anything but noted he did work 12 hours a day for the next four days.

This week—he missed Monday and Tuesday and I understand he was drinking. This man is good.

He is a top foreman—but talking to him doesn't seem to work. I've got a basic DECISION to make in regard to him.

Mr. Matheson's Decision

It is fundamental in Alcoholism that the alcoholic person seldom seeks help for his problem until he begins to bear the direct consequences of his behavior.

This employee has not borne any of these consequences. The family is still intact—in fact the wife has covered up for his absence which seemed essentially due to his drinking. The employer has talked to him, but has appeared to accept his explanations and even tends to make a less than valid argument in his favour by emphasizing that he makes up his time lost between drinking episodes.

The employer is faced with a delicate matter. The foreman used a traditional argument — "My drinking is personal and has nothing to do with the company."

However, our vocation, business or profession, particularly positions of responsibility, make certain personal demands upon us in terms of our behaviour, habits and conduct.

How far does the employer have to be pushed before he confronts the employee with the reality that his drinking is no longer entirely a personal matter but is adversely affecting the business in several areas?

1. The employee has repeatedly missed time at work—on one instance as long as four days. The job was messed up, with implied financial loss and an unsatisfied customer.
2. The foreman fired a painter for drinking on the job, thereby placing the employer in the embarrassing position of having to defend a senior employee whom he suspected of having a drinking problem. (This is implied but predictable.) So there follows unnecessary staff turnover, loss of morale, and personnel problems stemming from the diminishing effectiveness of the foreman's ability to supervise.

However, this is a valuable employee—the employer volunteers this:

He has been with the firm five years. If he were not good, he would not have been retained.

In the first year he cut operating costs substantially.

He has been earning $9,000 per year.

The company obviously has an investment in this man. The recruiting and training of new personnel is costly. Therefore, he is worth saving for the company.

The realities in terms of the foreman's drinking problem are:

He is the victim of a progressively impairing illness from which his chances of recovery without outside help are minimal.

However, with help he is treatable, and he has better than average chances for a positive recovery.

Like most sick people, he needs direction and limits should be established.

The employer can set this process in motion:

1. Refuse to further remonstrate with the foreman or permit him to explain, rationalize, project, or further excuse his behaviour on any grounds other than his drinking problem—no longer entertain extravagant promises beyond the employee's ability to fulfill.
2. Directly confront the employee with the fact that he is suspected of having an alcoholic problem. If you can cite examples that lead to this suspicion, so much the better. The term 'suspect' permits the employer to evade the role of specialist or diagnostician.
3. Define limits—while you're sympathetic personally to any health

problem, you're operating a business in which the reliability of key personnel is a fundamental factor.

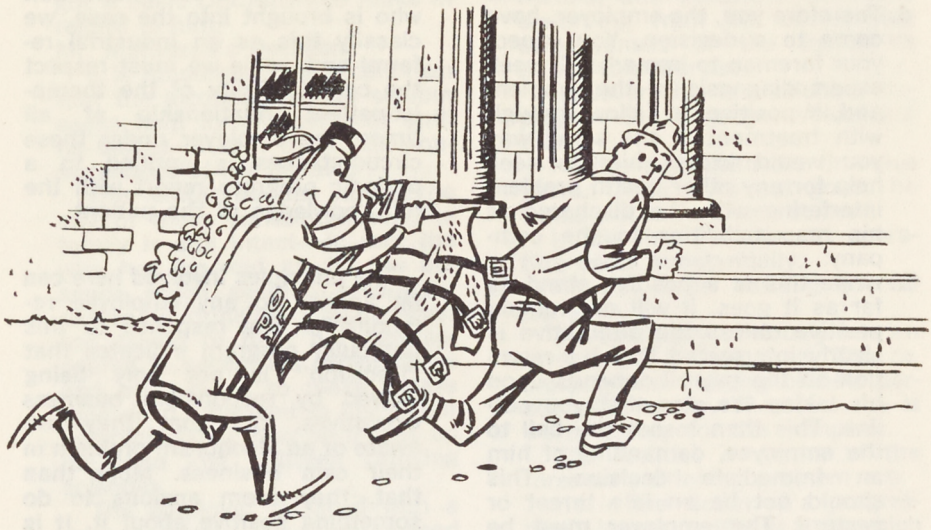
4. Therefore you, the employer, have come to a decision. You expect your foreman to immediately seek expert diagnosis of the problem and, if positive, to follow through with treatment in the same way you would expect him to seek help for any other health problem interfering with the discharge of his responsibilities to the company.
5. While this is a positive stand as far as it goes, it will not remain positive unless the alternative is clearly interpreted that his retention on the payroll depends upon his taking the step that you outline. This then tosses the ball to the employee, demanding of him an immediate decision. This should not be an idle threat or gesture. The employer must be prepared to follow through with what he has told the employee. The alcoholic will test, with better than average sensitivity, as to just how far he can go, and this employee has tested effectively in the past and manipulated things to his advantage. While the employee may impulsively quit, the employer has then merely advanced the date of the inevitable. Again, the chances are better than average that he will retain the services of a recovered and valuable employee.
6. If the foreman's decision is to seek professional or expert help, it is often advisable for the employer to make the appointment or contact for him, possibly in his presence. If it is our Foundation who is brought into the case, we classify this as an industrial referral and, while we must respect the confidentiality of the therapist-patient relationship at all times, the employer under these circumstances is entitled to a periodic progress report with the full knowledge of the patient.

The principles involved here can be applied to any employee relationship. The response to this particular program indicates that "Decision" is not only being viewed by responsible business executives, but that they are aware of an alcoholism problem in their own business. More than that, they seem anxious to do something positive about it. It is encouraging to note that the door is open in many places in business to establish active alcoholism programs within the framework of Personnel or Health and Welfare Departments.

*Title courtesy of Hudson's Bay Co. and CHCT-TV, Calgary.

Gordon A. Wemp serves on the Calgary staff of The Alcoholism Foundation of Alberta as Information Officer. He specializes in both lay and professional educational work, and is widely experienced in radio and television media.

An Old Grad Returns



A.T.I., dear Alma Mater, was a tough, no-frills school—but the Dean has problems . . .

THERE it was, the Alcoholic Training Institute, complete with institutional lawns and ivy-covered walls. Naturally, I was curious, being an alcoholic, so I went in to call on the Dean and ask him to show me around.

The Dean met me with a firm handshake. "A tour. Of course," he said. "We're proud of the Institute. It's filling a real need."

It took me no time at all to see that A.T.I. was not a "fun" school. The first door we opened took us into a classroom whirring with adding machines. Students were bent over columns of figures, biting on pencils.

"This is our course in Chequebook Reconstruction," the Dean explained. "We give each pupil a deposit slip for $500, a bank statement showing a balance of $1.86, and a chequebook that is complete except for six or seven stubs that weren't filled out. The task is to figure out how much each of the missing cheques was for and whom they were made out to."

I complimented the Dean. Creative bookkeeping is certainly a valuable skill for the alcoholic. We entered the next class room on tiptoe, for there was a sign on the door reading: "Quiet please — Cheque-Signing Class in Progress."

Here, the students were poised, pen in hand, before phonograph turntables. On each spinning platter there was a bank cheque.

"Actually," said the Dean, "when an alcoholic is out in the field, the cheques are standing still and his hand is moving. This amounts to the same thing."

He told me the beginning stu-

dents work on cheques spinning at 33⅓ rpm. Then they move up to 45 rpm, and near the end of the course, some of the brighter ones can scratch out a passable signature at 78 rpm.

We moved on, and from a pair of large double doors I heard a great clatter and thumping. My guess was right—it was the gymnasium.

The vast floor of the gym was strewn with a haphazard arrangement of tables, chairs, sofas, benches, platforms, sawhorses and tackling dummies. The gym students were crashing into these objects, slipping and falling, and it was obvious why—they were blindfolded.

"We toughen them up in here," the Dean said with zest.

I helped a young lady disentangle herself from a collapsible lawn chair. A young man limped past nursing a newly-blackened eye and the Dean said to him kindly, "Patience, lad. We can't all be lettermen."

Then I saw what probably was the most fascinating classroom of all. Or I should call it a laboratory.

"The speech lab!" announced the Dean proudly as he flung open the door. Students in soundproof booths were concentrating on sounds from tape recorders or speaking into microphones. At first I didn't understand why an alcoholic trainee needed to work on phonetics. The Dean detected my bewilderment, and called a student to our side.

"Smedley, here's a visitor," said the Dean. "Why don't you—uh—tell him what's ailing you."

Smedley's face twisted suddenly into a grimace, and with a croakish voice he muttered: "Asiatic flu. It's going around, you know. I should be able to shake it off in a day or so, but right now, I'm as weak as a kitten." Then he straightened up and beamed.

"Good work, Smedley." The Dean turned to me. "You see, we study the voice characteristics of every known affliction—tooth extractions, sinus trouble, asthma, odd types of flu. Our grads can counterfeit any ailment on the telephone. That's vital, of course, if an alcoholic is going to get anywhere at all."

Then we visited a room where one student was standing at a lectern and telling a story that had something to do with a flash-flood and a washed-out bridge. Other students were taking notes.

The Dean explained: "This is creative Alibis I. Pupils are graded on their ability to account for late arrivals or long absences. Right down the hall is Creative Alibis II. It's an advanced course. You have to account for missing days instead of hours."

We had nearly completed our circuit of the building when we walked past the open door of a room that didn't look like a classroom at all. It could have been the family room in a Westchester split-level. Some students were rummaging through cabinets, one had crawled halfway under the mattress on a daybed and one was up on a ladder fumbling at a light fixture.

"The Bottle-Finding Seminar," the Dean smiled. "There's a half-pint hidden somewhere in the room. Every alcoholic has this problem sooner or later. You know, he hides his supply in a perfect place and then can't remember where it is."

I pulled the Dean aside to ask the obvious question. He whispered: "See that hi-fi set in the corner? It's wedged between the woofer and the tweeter."

We were back at the entrance of the building and as I put on my hat and coat I asked the Dean about the alumni of A.T.I. What did he hear from the grads?

For the first time, the Dean's enthusiasm lapsed. "The fact is," he said, "We've yet to place an A.T.I.

man on Skid Row. Some of them haven't had a drink since they left. There's something wrong somewhere. I'm not sure, but it might be the final exam."

"A tough one?" I asked.

He beckoned me to an alcove. We faced a heavy door with double bolts, and through a small pane of thick glass I could see a tiny room—you might call it a cell—containing only a cot.

"To graduate, each senior has to spend 24 hours in there," the Dean said grimly. "It gets him accustomed to the isolation that every alcoholic must undergo. The trouble is, for 24 hours he has nothing to do but think. Do you think we're doing something wrong?"

"On the contrary," I told the Dean as I left. "The curriculum is perfect. I wouldn't change a thing."

R. Z., Phoenix, Arizona

Reprinted with kind permission from AA Grapevine, January, 1963 edition.

THE ROLE OF A UNIVERSITY IN AN APPROACH TO SOCIAL PROBLEMS

CHANGE in the twentieth century has resulted in the emergence of a variety of mixed social, economic, and medical problems that challenge society. Public concern is expressed over modifications of traditional patterns of family life, over alterations in the role of the church and of the school, and over deteriorating neighborhood and community relations. Efforts to resolve problems arising from urban decay, transportation deficiencies, unemployment, and our aging population by minimizing their significance or instituting purely palliative measures have been unproductive.

The average individual, observing what is happening in this process of change, finds it difficult to separate cause from effect. Recommendations offered by professionals trained in a single discipline are usually appropriate to one segment of the problem only, with the result that there is a lack of integration in corrective procedures.

Changes have similarly occurred in the perception of the use and non-use of alcoholic beverages among different groups in American life. Drinking practices frequently are thought to be primary factors in the intensification of social problems. For example, excessive drinking and alcoholism are presumed to play a primary role in family disorganization, economic and occupational impoverishment, court and correctional problems. To ascribe to the drinking custom major responsibility for a social problem which arises out of multiple causation represents an over-simplification.

Patterns of individual and social drinking are reasonably well defined and are measurable. By contrast, social problems such as delinquency, divorce, unemployment, and crime are amorphous. However, examination of an alcohol-related social problem through the medium of drinking or non-drinking provides an approach that allows new insights and suggests new directions.

By drawing on the resources of a university, it is possible to focus the experience and skills of a number of professional disciplines on an issue of social concern. Hypotheses may

be advanced and tested. Analysis and interpretation of data can delineate multiple factors in causation.

This exploration may demonstrate a need for a comprehensive social action program to be carried out by the community, institution, or agency primarily affected. The university's responsibility ordinarily will be limited to experimental or demonstration projects.

Students, both professional and lay, participating in a School of Alcohol Studies are able to draw on all of the resources of a university in their attempts to understand a series of social problems by analysis of the drinking patterns and customs of a group or sub-group. In this procedure critical definition and analysis of issues evolve. The likelihood of an intelligent attack on the problem at the community level is increased. It is within this general concept of the role of the university that the following objectives of the Summer School of Alcohol Studies have been formulated:

1. To examine within the context of the biological, psychological, and social sciences, and within the perspectives of relevant professional groups, the historical and contemporary functions served by the use and non-use of alcoholic beverages in Western cultures.

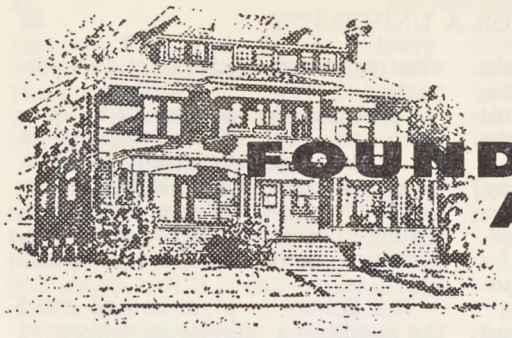
2. To identify and assess individual and group attitudes toward social drinking.

3. To analyze the impact of excessive drinking and alcoholism on the individual and on social institutions, and to evaluate the community responses elicited by this impact.

4. To provide opportunity for professionals and others responsible for control and alleviation of problems associated with alcohol to expand their perceptions and techniques through lectures, seminars, demonstrations, and library resources.

The School is organized to meet the needs of a number of categories of professional and nonprofessional groups. Professional workers presently active in the prevention or treatment of alcoholism — clergy, educators, physicians, nurses, case workers, psychologists—will have an opportunity to exchange experiences, review current literature and research findings, and redefine some of the principles they observe in practice. Enforcement and correctional officers, leaders in municipal and state affairs, traffic supervisors, personnel officers and foremen in industry, and others whose work requires a knowledge of alcohol problems will acquire a background of understanding through attendance at the School. Private citizens who wish to explore problems of alcohol as these problems are related to community life and social change will find their experiences at the School stimulating and challenging.

Reprinted by kind permission of Rutgers University Extension Division from their 1963 Summer School of Alcohol Studies calendar.



FOUNDATION ACTIVITIES

WINTER, 1963

TREATMENT

The demand for treatment services rose above that experienced in any previous period, and individual counselling interviews greatly exceeded the optimum for the number of counsellors available. Attendance at Day and Evening groups was higher than at any time in the past, and additional treatment services in the form of an Afternoon group, and also an Evening group for the teen-age children of patients, were provided. These new services were well used and will bcome a regular part of The Foundation's treatment program.

RESEARCH

In addition to ongoing studies, including internal assessments of The Foundation program and surveys of drinking patterns in licensed consumption outlets, research staff are currently examining such diverse topics as: causes of patient deaths; Skid Row, a preliminary ecological survey; legal age and social responsibility. A clinical pharmacological study is being conducted, as is also an investigation of the relationship of liver function to blood pressure.

EDUCATION

All Centres continued an active educational program in many segments of the community. Highlighting January activities was the film 'A Woman Alcoholic' produced at the Edmonton Centre in cooperation with the local CBC Television station; several talks to high school classes, and a script for a new radio program called 'Decision' produced in the Calgary Centre. Both Edmonton and Calgary radio and TV stations featured appearances by Foundation staff; and the addition of a new wing to the Calgary Centre was widely publicized. The Foundation looks forward to increasing use of these media in the future.

OTHER FOUNDATION SERVICES

- **ADVISORY SERVICES:**
  Professional advice and assistance on the problems of alcoholism

- **AUDIO-VISUAL AIDS:**
  Films, tapes, records, and displays are available on loan

- **CONFERENCES and SEMINARS:**
  To create a better understanding of the problems of alcoholism and methods of dealing with those problems

- **INDUSTRIAL WORKSHOPS:**
  For the education of management, supervisory staffs, and general employees in Alberta industry

- **ORIENTATION PROGRAMS:**
  For nurses, doctors, internes, penal officials, personnel managers, social workers, clergymen, teachers, and other groups

- **PUBLICATIONS:**
  Progress, Digest on Alcohol Studies, and original brochures and pamphlets

- **REFERENCE LIBRARY:**
  Books, pamphlets, and publications by authorities in the field of alcoholism

- **SPEAKERS' BUREAU:**
  For professional, industrial, church, social, school, civic, and other groups requesting information

The illustrations in Progress are by Harry Heine

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